

# Hydrafacial™ Treatment Consent Form

Hydrafacial is the only hydradermabrasion treatment that combines cleansing, exfoliation, extraction, hydration and antioxidant protection simultaneously, resulting in clearer, more beautiful skin with little-to-no downtime. The treatment is soothing, moisturizing, non-invasive and generally non-irritating. As with most procedures, visible results from Hydrafacial will vary from person to person.

## What to expect:

- Your skin may experience temporary irritation, tightness, or redness. These are all normal reactions that typically resolve within 72 hours depending on skin sensitivity.
- You may experience tingling and stinging in the treatment area. These sensations generally subside within a few hours.
- Client experiences may vary. Some clients may experience a delayed onset of these symptoms.
- You will likely see results immediately after treatment and your skin may feel smooth and hydrated for one to four weeks with appropriate home care to maintain treatment results.
- The skin is more susceptible to sunburn/sun damage. Avoid excessive sun exposure and use a minimum of SPF 40 sunscreen.

## Do you have any of the following?\*

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Active acne or infection _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Open lesion or cold sore _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| An active infection in the treatment area _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Active sunburn _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin conditions such as eczema, dermatitis, or rashes _____                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| An autoimmune disease such as lupus _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A viral concern such as HIV or hepatitis _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anticoagulants Therapy _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Melanoma or lesions suspected of malignancy _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pregnancy or lactation _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neurological disorders such as epilepsy (LED Lights) _____                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Infection in the urinary system i.e. kidneys, bladder and urethra (Lymphatic drainage) _ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Crohn's Disease (Lymphatic drainage) _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hyperthyroidism (Lymphatic drainage) _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Deep Venous Thrombosis (Lymphatic drainage) _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lymphedema (Lymphatic drainage) _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

\*Saying yes does not preclude you from receiving treatments.

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Have you recently?\*

Used Accutane, topical medications or antibiotics \_\_\_\_\_  Yes  No

Had aesthetic fillers, injectables or laser treatments \_\_\_\_\_  Yes  No

I acknowledge the following:

- I will avoid the use of aggressive exfoliation, waxing, and products containing glycolic acids or retinols that are not part of the recommended take-home regimen in the treated areas for minimum 2 weeks pre-and post-treatment.
- Photos may be taken before, during and after the Hydrafacial treatment. Photos will only be used with my written approval for education, promotion or advertising purposes.
- The information provided has been explained to me and all my questions have been answered to my satisfaction. I have read the above information, and I give my consent to have the Hydrafacial treatment by the staff at \_\_\_\_\_.
- By signing below, I acknowledge that I have read the above information and give my consent to be treated with the Hydrafacial System. This consent form is valid for all future Hydrafacial treatments. I will alert the staff if there are any future changes to my medical history.

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_